

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of any and all injuries.

BP

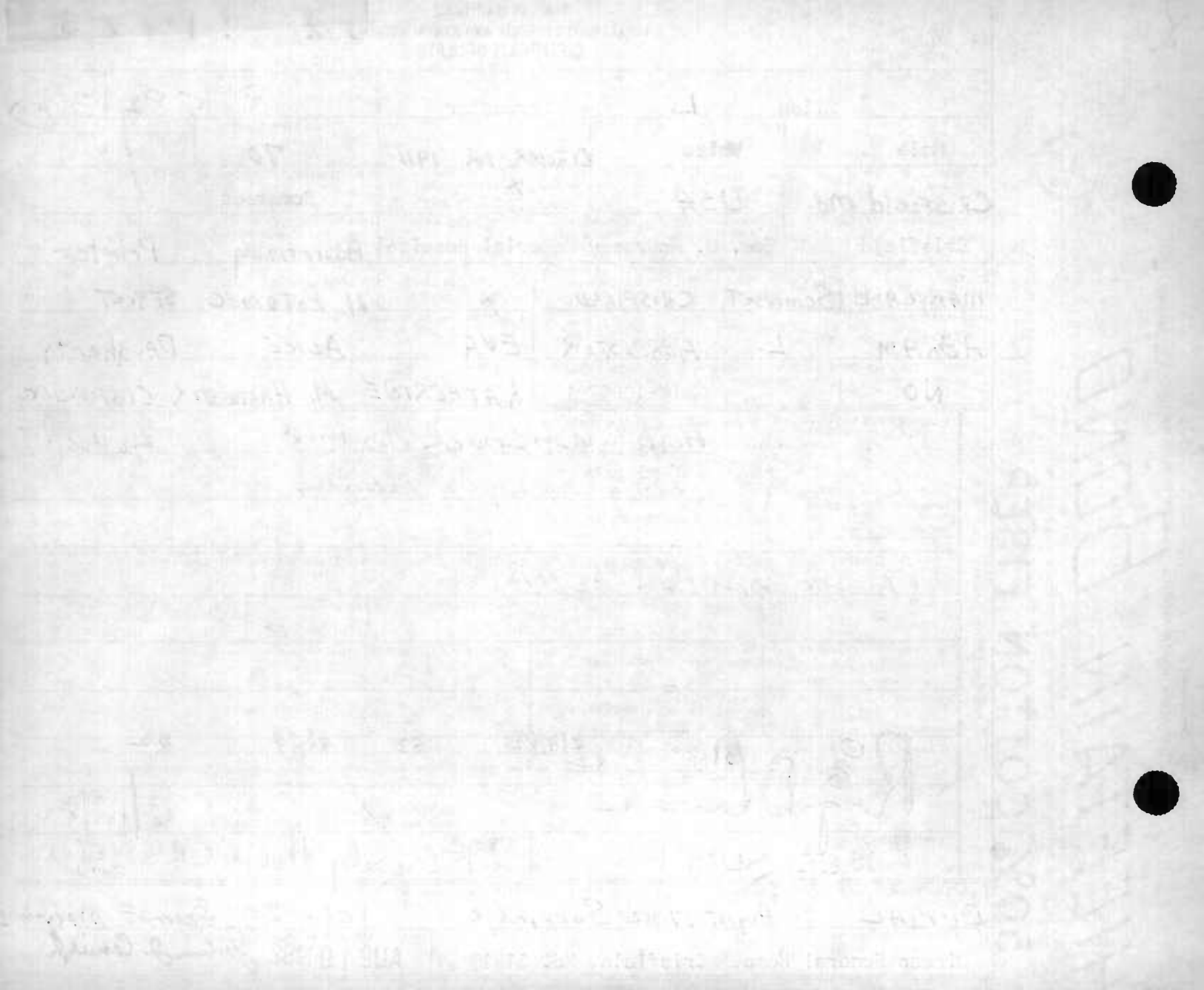
DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|--|--|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Allen L. Hardester | | | 2a. DATE OF DEATH MONTH DAY YEAR 8 15 82 | | 2b. HOUR 3:25 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 12 1911 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 1 YEAR HOURS MIN. | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Crisfield md. | | 9b. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 11. CITY OR TOWN OF DEATH Crisfield | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edw. W. McCready Memorial Hospital | | 13. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD. | | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE 14b. COUNTY 14c. CITY OR TOWN MARYLAND Somerset CRISFIELD | | 15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16. STREET ADDRESS 11 POTOMAC STREET | | |
| 17. FATHER'S NAME FIRST MIDDLE LAST ABRAM L. HARDESTER | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA ALICE DAUGHENTY | | 19. ADDRESS KATHERINE M. HARDESTER CRISFIELD MD. | | |
| 20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 20b. SOCIAL SECURITY NO. 214-10-9791 | | 21. INFORMANT KATHERINE M. HARDESTER CRISFIELD MD. | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension, Shock, Anemia 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Lung Cancer, GI Bleeding DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 Hrs. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Hemiparesis, ASHD. | | | | | | |
| 23a. DATE OF OPERATION - | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 24. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR - P.M. 19 | | 26. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) - | | |
| 27. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 28a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) - | | 28b. LOCATION STREET CITY OR TOWN COUNTY STATE - | | |
| 29. I certify that (I) (this hospital) attended the deceased from 8/19/82, 1982, to 8/15/82, 1982, that (I) (we) lost saw the deceased alive on 8/15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death. | | | | | | |
| 30. SIGNATURE Roger Suarez | | 31. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 32. DATE SIGNED 8/15/82 | | |
| 33. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER SUAREZ | | 34. ADDRESS McCready Hosp CRISFIELD MD | | | | |
| 35. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 36. DATE August 17, 1982 | | 37. NAME OF CEMETERY OR CREMATORY Sunnyridge | | |
| 38. LOCATION CITY OR TOWN COUNTY STATE CRISFIELD Somerset MARYLAND | | 39. DATE REC'D. BY REGISTRAR AUG 19 1982 | | | | |
| 40. FUNERAL DIRECTOR NAME Hinman Funeral Home, Crisfield, Md. 21817 | | 41. REGISTRAR'S SIGNATURE John J. Canine | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 1 9 7 6 | |
|---|--|---|--|--|--|--|--|---|--|---------------|--|
| FOR 1 - STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William N. Justice | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 8 17 82 | | 2b. HOUR 5:05P M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD | | | | | |
| 10. CITY OR TOWN OF DEATH Crisfield | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Alice Byrd Tawes Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder | | 12b. KIND OF BUSINESS OR INDUSTRY Boat Industry | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Crisfield | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward L. Justice | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Nelsie Maddrix | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. II 214-03-5114 | | 17. INFORMANT ADDRESS Nora H. Justice Same as a3 a,b,c,d,e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 2507 DUE TO, OR AS A CONSEQUENCE OF (b) Decubitus ulcers DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 3 mos 20 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-30 , 19 82 , to 8-17 , 19 82 , that (I) (we) lost saw the deceased alive on 8-10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE C. Stegman | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 8-19-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Stegman, M.D. | | | | 22e. ADDRESS Princess Anne, Maryland 21853 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY American Legion Ceme | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield Somerset Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Bradshaw & Sons | | | | ADDRESS Crisfield, Md. 21817 | | 25a. DATE OF DEATH AUG 23 1982 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Canine | | | | | |

BP



1. The first part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated 1911. The letter is signed by the Secretary of the Department of the Interior and is addressed to the Secretary of the Department of the Army.

2. The second part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated 1911. The letter is signed by the Secretary of the Department of the Interior and is addressed to the Secretary of the Department of the Army.

3. The third part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated 1911. The letter is signed by the Secretary of the Department of the Interior and is addressed to the Secretary of the Department of the Army.

8 2 2 1 9 7 7

FOR STATE
HEALTH DEPT.

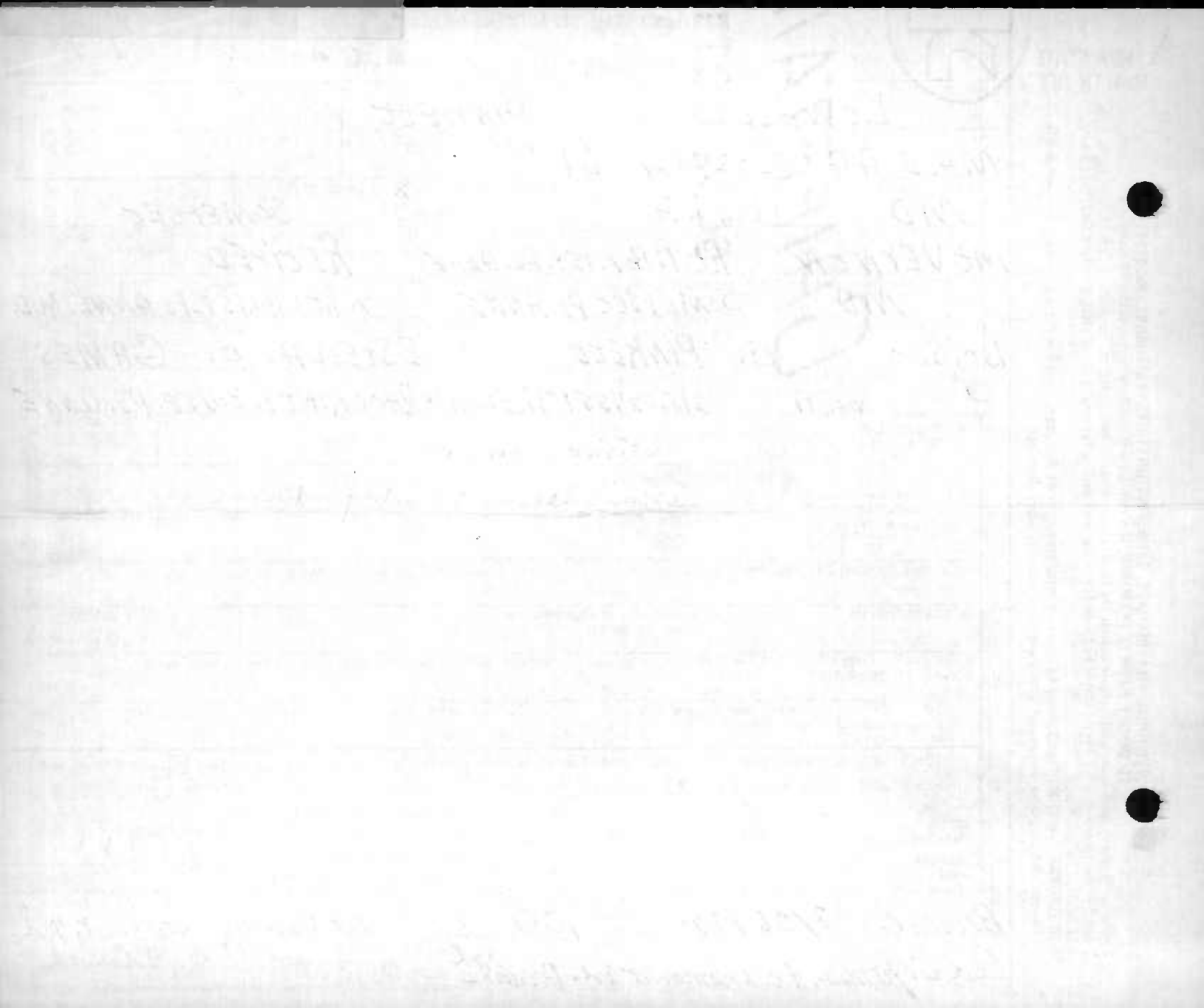
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|-----------------------|--|--|--|--|--|--|--|---------------------|
| 1. DECEASED NAME (Type or Print) LOWELL V PINKETT | | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month 8 Day 22 Year 1982 | | | 2b. HOUR 8:00 PM | | | |
| 3. SEX MALE | 4. RACE AA2 | 5. DATE OF BIRTH 3-5-1921 | 6. AGE (In years last birthday) 61 YRS. | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | | IF UNDER 24 HRS HOURS _____ MIN _____ | | 2c. DATE PRONOUNCED DEAD Month _____ Day _____ Year 19 | 2d. HOUR M _____ |
| 7a. BIRTHPLACE (State or foreign country) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH SOMERSET Md. | | | |
| 10. CITY OR TOWN OF DEATH MT VERNON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) REI. Bldg. 158. Pt. ANNE | | 12a. USUAL OCCUPATION (Kind of work done during most of or immediately preceding period.) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | 13b. COUNTY SOMERSET | | 13c. CITY OR TOWN Pt. ANNE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER REI. Bldg. 158. Pt. ANNE. M.D. | |
| 14. FATHER'S NAME First Middle Last Brisco C. PINKETT | | 15. MOTHER'S MAIDEN NAME First Middle Last ESTELLA. O. GAMES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <input checked="" type="checkbox"/> NO | | 16b. SOCIAL SECURITY NO. 215-037357 | | 17. INFORMANT ADDRESS THELMA RHOCK. REI. Bldg. 158. Pt. ANNE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CRIME - ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADVANCED CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE S. J. M. M.D. | | EXAMINER'S NAME (Type) _____ | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 8/25/82 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 8/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY St Paul | | 23d. LOCATION (City or Town) (County) (State) Mt. Vernon. Somerset. Md | | | |
| 24. FUNERAL DIRECTOR Addis Jones, 407 Somerset Ave. Pt. Anne Md | | ADDRESS _____ | | 25a. REC'D BY REGISTRAR DATE AUG 30 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conish | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

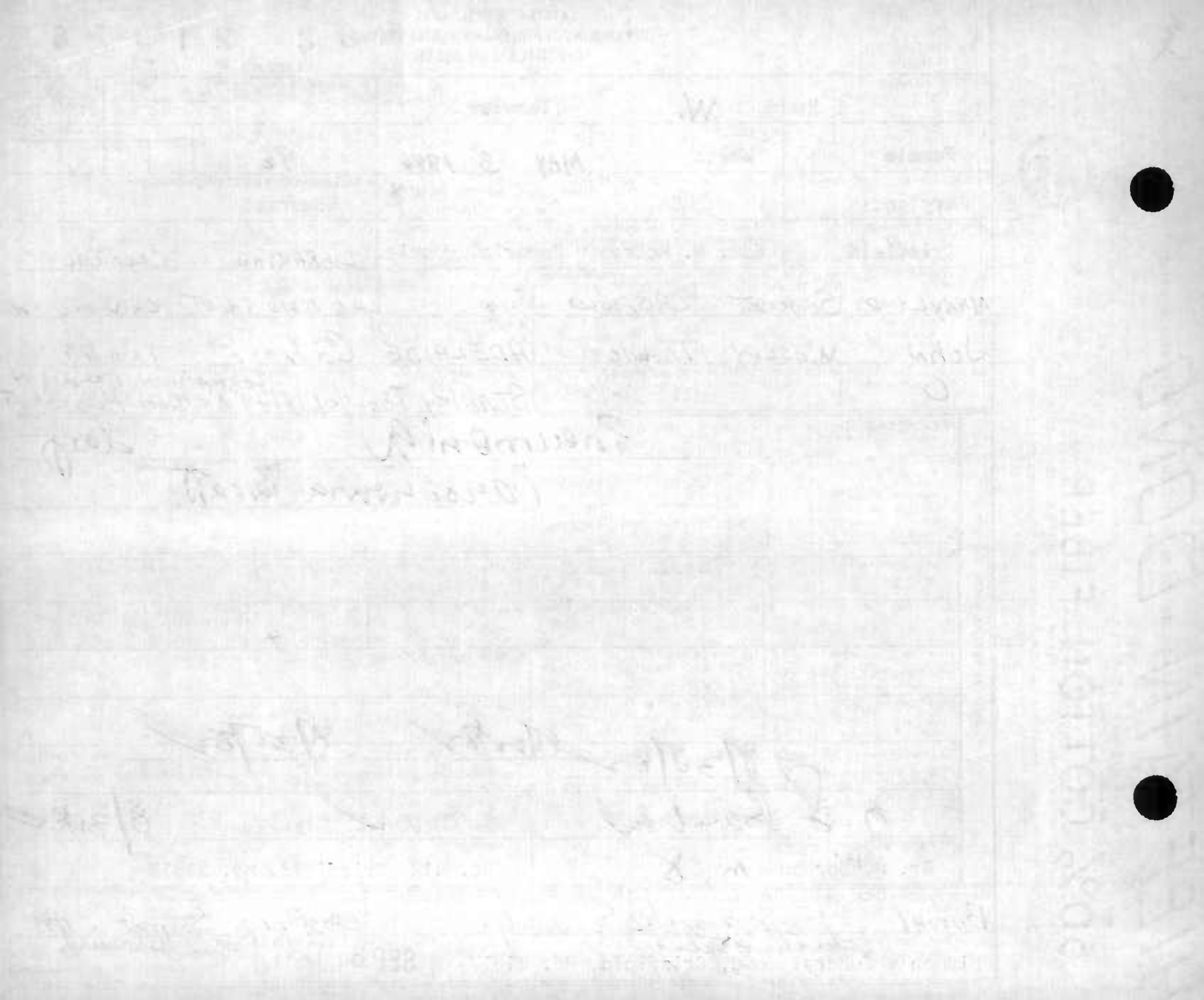
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 8 2 2 1 9 7 8 | | |
|---|--|--|---|---|------------------------|--|--|
| 1. FOR STATE REGISTRAR FOR DECEASED NAME (TYPE OR PRINT) JOSIE W. Thawley | | | 2a. DATE OF DEATH MONTH DAY YEAR 8-30-82 | | 2b. HOUR 1:40 PM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 3 1986 | | 6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD. | |
| 10. CITY OR TOWN OF DEATH Crisfield | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edw. W. McCreedy Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LIBRARIAN | | 12b. KIND OF BUSINESS OR INDUSTRY CLERICAL | |
| 13a. STATE MARYLAND | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN CRISFIELD | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John WESLEY Thawley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELAIDE COCHRANE Thawley | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 0 | | 16b. SOCIAL SECURITY NO. 218-34-7608 | |
| 17. INFORMANT STANLEY Thawley | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1749</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>day</u> | | 17c. STREET ADDRESS 36 MAIN STREET CRISFIELD, MD | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/30/82</u> , 19 <u>82</u> , to <u>8/30/82</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>8/30/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>M. D. Barhan</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>8/31/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. M. Barhan | | 22e. ADDRESS Rt. #413, Crisfield, Md. 21817 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>September 1, 1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunnyridge</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>CRISFIELD Somerset Md.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Legle Stueley</u> | | 24b. ADDRESS Hinman's Funeral Home, Crisfield, Md. 21817 | | 25a. DATE REC'D. BY REGISTRAR SEP 3 1982 | | | |

BP



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BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 1 9 7 9

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Earl B. Ward | | | 2a. DATE OF DEATH MONTH DAY YEAR 8-13-82 | | 2b. HOUR 2:15 p.m. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 10, 1902 | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD. | | |
| 10. CITY OR TOWN OF DEATH Crisfield | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edw. W. McCready Mem. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Mason | 12b. KIND OF BUSINESS OR INDUSTRY Concrete | |
| 13a. STATE Maryland | | | 13b. COUNTY Somerset | 13c. CITY OR TOWN Westover | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ross Ward | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Landon | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no none | | 16b. SOCIAL SECURITY NO. 217-03-4785 | 17. INFORMANT ADDRESS Carrie I. Ward Same as 13 a, b, c, d, e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> days 5751 } DUE TO, OR AS A CONSEQUENCE OF <u>CARDIAC Arrest</u> days Conditions, if any, which } DUE TO, OR AS A CONSEQUENCE OF <u>Peritonitis</u> days gave rise to immediate } cause (a), stating the } underlying cause last } (c) <u>Ch. lymphatic leukemia</u> days PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Ch. lymphatic leukemia</u> days <u>acute cholecystitis</u> days <u>Peritonitis</u> days | | | | | |
| 19a. DATE OF OPERATION 8/11/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>acute cholecystitis</u> <u>Peritonitis</u> | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/8/82</u> , 19 <u>82</u> , to <u>8/13/82</u> , 19 <u>82</u> , that (if we) lost saw the deceased alive on <u>8/13/82</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>M. M. Barhan</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>8/16/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. M. Barhan | | 22e. ADDRESS Rt. #413, Crisfield, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/16/82 | 23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield Somerset Md. |
| 24. FUNERAL DIRECTOR NAME Bradshaw & Sons, Crisfield, Md. 21817 | | | 25a. DATE REC'D. BY REGISTRAR AUG 19 1982 | | |

MEDICAL CERTIFICATION

1/20/12
1/20/12
1/20/12
1/20/12

Cardiac Arrest
1/20/12
1/20/12
1/20/12

1/20/12

1/20/12
1/20/12
1/20/12
1/20/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 21980 | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST Gladys White | | 2a. DATE OF DEATH MONTH DAY YEAR August 12 1982 | | 2b. HOUR 24 M | | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR June 3 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD | | | | | |
| 10. CITY OR TOWN OF DEATH Deal Island | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Main Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher | | 12b. KIND OF BUSINESS OR INDUSTRY school | | | |
| 13a. STATE Md | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Deal Island | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Main Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dorsey V. Milbourne | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Bivens | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -- | | 17. INFORMANT ADDRESS UNAVAILABLE Melvin White, Deal Island, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AS Coronary Disease (c) DUE TO, OR AS A CONSEQUENCE OF Hypertension, Heart Failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (as a hospital) attended the deceased from 1955 to 8-12-82, that (I) (as a) saw the deceased alive on 7-10-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Everett S. Miller | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 8-13-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVERETT S. MILLER | | | | 22e. ADDRESS DAMES QUARTER INC | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 8/14/82 | | 23c. NAME OF CEMETERY OR CREMATOR John Wesley Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Deal Isl. Som. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Leroy G. Webster | | | | ADDRESS Rt. 3, Box 354 Pr. Anne, Md. | | 25a. DATE REC'D. BY REGISTRAR AUG 18 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | |

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